

Last Name: _____
First Name: _____
Address: _____
City, State: _____
Daytime Phone:(_____) _____
E-mail: _____
Licensed in what state(s): _____
Specialty (s): _____
Board Certified: _____
Board eligible? _____

(PLEASE PRINT OR TYPE)

Degree: _____

(Please write name as it should appear on the CME certificate)

Zip: _____

Fax (_____) _____

COURSE FEE (SPECIFY _____)

COURSE FEE (SPECIFY _____)

\$80 whole day / \$50 half day
(includes breakfast and lunch)

Register by January 31st, 2006

Make check payable to:

Polish-American Medical Society

Registration fee has been waived for students, residents, and non-practicing physicians.